California MEDICINE

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EDITORIAL

Labor and Medicine

LABOR'S ILLS in the field of medical care were exposed to the view of the public and several hundred labor leaders in a San Francisco conference concluded March 21.

Called by Mr. George Johns, secretary of the San Francisco Labor Council, the conference spent two days in several panel meetings, exploring avenues for labor to follow in trying to get what it wants in medical care at the price it is prepared to pay.

At stake in this discussion is the pattern of medical care to be purchased by and supplied to members of labor unions in the San Francisco area—some 187,000 workers plus their dependents.

Aside from several decisions reached in terms of straight criticism of things as they are, the results of the conference asked for action on several points where the group felt it had not been adequately cared for in the past. Among other things, the conference reiterated its support of national compulsory health insurance as labor's ultimate goal. It also called for the establishment of labor health centers, to be staffed by physicians employed by labor. It demanded the elimination of "abuses" by physicians in caring for insurance-covered union members and discarded the suggestion that co-insurance, under which the individual would be asked to assume some financial responsibility for his own health care, be accepted as policy.

Behind this conference lies the history of Mr. Johns and his group in the past few years. This history started with the compilation of a "health survey" by Dr. Richard Weinerman, formerly associated with the School of Public Health of the University of California and later with the Kaiser organizations. This study sought to prove that the only way labor could achieve its goal of complete medical and hospital care at the cost it was prepared to pay was to establish its own health centers and its own paid medical staff.

San Francisco physicians rebelled at this suggestion and pointed to its obvious scientific defects, especially its potential proclivity toward reduced standards of scientific medical care. In the face of this opposition, the San Francisco Labor Council has not taken any publicly announced steps to implement the medical center idea.

Now, after months of inactivity, the two-day conference reverts to the medical center plan as the solution to labor's medical care problem, simultaneously admitting that this is simply a stop-gap until national socialized medicine can be secured.

The conference also found that the Kaiser plan of closed panel medical practice in selected hospitals is the "most attractive one" available to organized labor today. This type of practice has been termed by many physicians as one which makes "captive patients" of its members and "captive doctors" of its employed physicians. Medicine as a whole has urged the retention of the free choice principle for physicians and hospitals as the system most likely to provide good medical and hospital care.

When the House of Delegates of the California Medical Association meets next month, the lessons of this labor conference will doubtless come in for considerable discussion. The suggestions of the Medical Services Commission will be before the delegates for consideration and it is likely that still other suggestions will be forthcoming.

Medicine is being called upon to provide a service at a price. Whether or not the price is right remains to be seen. Whether or not medicine can go far enough to meet the present demands, at the price offered, is still a moot question.

The only conclusion obvious at this writing is that a great deal of education will be required in the months to come. Physicians and labor alike will need education in the various phases of medical economics involved in this complex problem. Physicians must meet the ever-present public demand for the provision of good medical care at a rate the public can and will pay. Labor must meet its obligations to the public, to employers and to physicians in recognizing the economic limits beyond which good medical care cannot go. Possibly the familiar pattern of collective bargaining tactics will again emerge, where labor asks for more than it expects to get and settles for less than the maximum demand.

Members of the House of Delegates will have a chance to ponder these considerations, among others, at the forthcoming meeting. The amount of thought given to this problem between now and the meeting date may well have an important bearing on the decisions subject to distillation by the House of Delegates. The end product is most important.

New Health Director

GOVERNOR GOODWIN J. KNIGHT'S APPOINTMENT of Dr. Malcolm H. Merrill as State Director of Public Health brings to this important post a man with a wealth of experience, a wide knowledge in his field and a splendid relationship with local health officers, medical societies, health organizations and all those interested in maintaining the highest possible public health standards. The California Medical Association recommended this appointment to the Governor and is pleased to see the recommendation followed. Dr. Merrill succeeds Dr. Wilton Halverson, who resigned not long ago after a number of years of outstanding service in the position to accept a full-time post with the University of California at Los Angeles.

The Council of the Association has already assured both the Governor and Dr. Merrill of its complete cooperation in all vital matters of public health. Congratulations are due both these men on the appointment now made. The beneficiaries will be the people of the state of California.

LETTERS to the Editor . . .

Can Panels Survive?

THE OPERATION of group plans for rendering medical care preceded the use of prepayment plans by many years, but the development of prepayment plans combined with the group-closed panel system has been comparatively recent. More significant is the impetus for expansion given the group principle by the use of the prepayment technique. It is understandable that business men have been attracted to the organization of closed panel medicine because it lends itself to patterns of commercialization and to objectives with which they are familiar.

The service type of prepayment medical care plans which render care through cooperative organizations of M.D.'s do not have the actuarial experience to be so precise in their costs as other types of insurance. This is so because the doctor alone is responsible for the kind and type of medical care the patient receives and no third party tries to direct it. It does, however, get the doctor the patient wants for himself, and makes use of the principle of prepayment.

The indemnity type of plan has a sound insurance principle so far as the underwriter is concerned: so many dollars will be paid for a listed procedure. If the amount of the indemnity does not cover the cost of the service to the patient, the patient must pay the difference. This defect is eliminated when there exists a contract with those rendering the care to adhere strictly to the schedule. When such an agreement exists, it usually results in the setting up of a closed panel of physicians who are then competing with their confreres on the basis of being on the panel and the price of service alone. This limits the choice of physician by the patient as well as the choice of the patient by the physician.

The closed-panel, utilizing the prepayment plan, offers to sell medical care to the public for a stated premium, the services to be rendered by members of the panel. These panels are usually made up of doctors who are giving attention to cases within their specialty. The free choice of physician by the patient is necessarily limited and the device tends toward the creation of a monopoly. What is the effect of the three different plans on the quality of medical care? This is a difficult matter to assay accurately. It is doubtless possible for good care to be given in any of these plans, where only the medical needs of